

Public Health and Health Planning Council

Codes, Regulations and Legislation Committee Meeting Agenda

September 12, 2024

10:15 a.m.

Empire State Plaza, Concourse Level, Meeting Room 6, Albany

I. WELCOME AND INTRODUCTION

Thomas Holt, Chair of the Committee on Codes, Regulations and Legislation

II. REGULATIONS

For Adoption

24-03 Amendment of Part 12 of Title 10 NYCRR and Section 505.2(e) of Title 18 NYCRR
(Reproductive Health Care Standards)

24-02 Amendment of Section 2.6 of Title 10 NYCRR (Disease Outbreak
Investigation and Response Clarifications)

23-20 Addition of Section 405.46 to Title 10 NYCRR (Hospital Cybersecurity Requirements)

III. ADJOURNMENT

******Agenda items may be called in an order that differs from above******

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by sections 201, 206 and 225 of the Public Health Law, Part 12 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 12.13 is REPEALED.

Section 12.20 is REPEALED.

A new section 12.21 is added, under the new title “REPRODUCTIVE HEALTHCARE STANDARDS,” to read as follows:

Section 12.21. Determination of blood group and Rh type and administration of Rh immune globulin.

(a) It shall be the duty of the physician, licensed midwife or nurse practitioner attending a pregnant person to take or cause to be taken a sample of their blood to determine blood group and Rh type in accordance with evidence based clinical guidelines.

(b) It shall further be the duty of the attending physician, licensed midwife or nurse practitioner to evaluate every such patient for the risk of sensitization to Rho (D) antigen in accordance with evidence based clinical guidelines and if the use of Rh immune globulin is indicated, and the patient consents, to cause an appropriate dosage thereof to be administered as clinically indicated.

Pursuant to the authority vested in the Commissioner of Health by sections 363-a(2) and 365-a(2) of the Social Services Law, subdivision (e) of section 505.2 of Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

505.2 Physicians' services.

* * *

(e) Abortion.

(1) Definition. [An abortifacient act is the procedure or procedures by which an abortion is induced and completed; this being either medical, surgical or both, the words abortifacient act refer to either or both.] For purposes of this section, an abortion shall include medication and procedural abortion that both a pregnant person and provider agree are needed.

[(2) Where care may be provided. An abortifacient act shall be performed subject to the requisites set forth in 10 NYCRR 12.20.]

[(3)](2) Who may provide service. [(i)] Abortion may be performed by a health care practitioner licensed, certified, or authorized under title eight of the Education Law, acting within their lawful scope of practice. [An abortifacient act is an obstetrical procedure and shall be performed only by a physician with a currently valid license to practice medicine and surgery in the State of New York and in accordance with the medical staff rules of the hospital or qualifying facility where the abortifacient act is performed.]

(ii) No physician or other person shall be required to perform or participate in a medical procedure which may result in the termination of a pregnancy.]

[(4)] (3) Establishment of diagnosis of pregnancy. Prior to the performance of an abortion[al act], the health care practitioner must determine and document the estimated duration of the pregnancy in accordance with evidence based clinical guidelines and section 2599-bb of the Public Health Law. [positive evidence of pregnancy by test result, history and physical examination or other reliable means shall be recorded on the patient's medical chart, with an estimate of the duration of the pregnancy.]

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for the proposed revisions is set forth in Public Health Law (PHL) sections 201, 206 and 225, as well as Social Services Law (SSL) sections 363-a(2) and 365-a(2). Section 201(1)(l) of the PHL establishes the powers and duties of the New York State Department of Health (Department), which include promoting diagnostic and therapeutic services for maternal health, as well as acting as the single state agency for the provision of the medical assistance program, also known as Medicaid. Section 206 of the PHL requires the Commissioner of Health to establish rules and regulations for the determination of asymptomatic conditions including Rh sensitivity, and establishes the Commissioner's authority to enforce the PHL, the State Sanitary Code and the requirements of the medical assistance program. Section 225 of the PHL sets forth the powers and duties of the Public Health and Health Planning Council (PHHPC), which include the authority to establish, amend and repeal the regulations known as the State Sanitary Code, subject to the approval of the Commissioner of Health. Further, section 225(5)(a) of the PHL allows the State Sanitary Code to address any matter affecting the security of life or health, or the preservation or improvement of public health, in New York State.

Additionally, SSL section 363-a(2) establishes the Department's authority to promulgate regulations needed to implement the medical assistance program, and SSL section 365-a(2) requires the Department to determine the scope of standard coverage under the medical assistance program.

Legislative Objective:

The legislative objective of sections 201, 206 and 225 of the PHL are to ensure that the Department of Health, through the Commissioner of Health and PHHPC, protect public health by adopting regulations in the State Sanitary Code (SSC) that effectively promote diagnostic and therapeutic services for maternal health and establish rules for the determination of asymptomatic conditions such as Rh sensitivity. In accordance with that objective, this regulation amends the SSC by revising Title 10 of New York Codes, Rules and Regulations (NYCRR) Part 12 to accord with provisions of the Reproductive Health Act of 2019.

Additionally, SSL section 363-a(2) establishes the Department's authority to promulgate regulations needed to implement the medical assistance program, and SSL section 365-a(2) requires the Department to determine the scope of standard coverage under the medical assistance program.

Needs and Benefits:

Neither Part 12 of Title 10 nor Part 505 of Title 18 has been modified since the passage of the Reproductive Health Act of 2019, and the provisions subject to amendment in this proposal derived their authority from PHL, section 4164, which was repealed by the Reproductive Health Act. Consequently, the proposed amendments are necessary to reconcile the regulations with the statute in its current form.

The Reproductive Health Act added a new Article 25-A to the PHL that expanded the types of otherwise qualified health care practitioners who may perform abortions, enshrined a fundamental right to carry a pregnancy to term, give birth to a child, or have an abortion, and explicitly stated that it was “the intent of the legislature to prevent the enforcement of laws or regulations that are not in furtherance of a legitimate state interest in protecting a woman's health

that burden abortion access.” As such, it is necessary to repeal section 12.20 of Title 10 and the corresponding provisions of subdivision 505.2(e) of Title 18.

What is now compartmentalized as section 12.13 of Title 10 contains two provisions applicable to abortion care that are inconsistent with both current standards of clinical care and recent changes to the abortion provisions in regulations authorized by Article 28 of the PHL. Moreover, it is both legally inaccurate and medically inappropriate that regulations governing abortion care be organized under a heading entitled “Protection of Infants and Children Against Hazards,” when in fact these provisions are meant to protect the health and lives of people of childbearing age. For that reason, the proposal will create a new subject heading under Part 12 entitled “Reproductive Healthcare Standards,” to clarify the regulation’s relevance and better facilitate public access to its contents.

Additionally, the rulemaking will amend subdivision of 505.2(e) of Title 18 to modernize the definition of abortion to expressly include medication and procedural services as deemed appropriate by patient and physician; to clarify that abortion services may be provided by any healthcare practitioner licensed in New York State and acting within their lawful scope of practice; and to clarify that said practitioners should determine a patient’s estimated duration of pregnancy in accordance with the requirements of PHL section 2599-bb and evidence-based clinical guidelines.

COSTS:

Costs to Private Regulated Parties:

There are no anticipated costs to regulated parties, including physicians, licensed midwives and nurse practitioners attending a pregnant person, because the current regulations already require these individuals to take or cause to be taken a sample of blood to determine blood group and Rh type. In addition, the changes to Title 18 modernize and clarify the

definition of abortion but make no actual changes to current provision of services or scope of practice. Therefore, there are no anticipated costs to regulated parties.

Cost to Local Government:

There are no anticipated costs to local governments associated with this regulation.

Cost to the Department of Health:

There are no anticipated costs to the Department of Health associated with this regulation.

Cost to Other State Agencies:

There are no anticipated costs to other state agencies associated with this regulation.

Local Government Mandates:

This regulation imposes no new government mandates.

Paperwork:

This regulation does not impose any new paperwork requirements.

Duplication:

This regulation does not duplicate, overlap, or conflict with relevant rules or other legal requirements of the State or federal government.

Alternatives:

An alternative to these regulatory amendments would be not to make any changes and to keep the regulations as written. However, these amendments are needed to bring the regulations into compliance with Article 25-A of the PHL, and therefore this was not considered a viable alternative.

Federal Standards:

The proposed regulations do not duplicate or conflict with any federal statutes or regulations.

Compliance Schedule:

This regulation will be effective immediately upon publication of a Notice of Adoption in the New York State Register. These proposed rules conform current regulation to existing State statutes.

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**STATEMENT IN LIEU OF
REGULATORY FLEXIBILITY ANALYSIS
FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS**

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments. There was no small business or local government participation in the development of these regulations. Local government should not be impacted by these proposed regulations.

**STATEMENT IN LIEU OF
RURAL AREA FLEXIBILITY ANALYSIS**

No Rural Area Flexibility Analysis is required pursuant to section 202-bb of the State Administration Procedure Act (SAPA). It is apparent from the nature of the proposed amendment that it will not impose any adverse impact on rural areas, and the rule does not impose any new reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. These provisions apply uniformly throughout New York State, including all rural areas.

**STATEMENT IN LIEU OF
JOB IMPACT STATEMENT**

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Section 225 of the Public Health Law, Section 2.6 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

2.6 Investigations and Response Activities.

(a) Except where other procedures are specifically provided in law and consistent with any direction that the State Commissioner of Health may issue, every local health authority, either personally or through a qualified representative, shall, with all due speed [immediately] upon receiving a report of a case, suspected case, outbreak, or unusual disease[,], and as the circumstances may require, investigate the circumstances of such report at any and all public and private places in which the local health authority has reason to believe, based on epidemiological or other relevant information available, that such places are associated with such disease. Except as consistent with any direction that the State Commissioner of Health may issue, s[S]uch investigations and response activities shall[, consistent with any direction that the State Commissioner of Health may issue]:

* * *

(6) With the training or assistance of the State Department of Health as necessary, examine the processes, structures, conditions, machines, apparatus, devices, equipment, records, and material within such places that may be relevant to the investigation of disease or condition;

* * *

(c) Investigation Updates and Reports.

- (1) Upon request of the State Department of Health, the local health authority shall submit updates and reports on outbreak investigations to the State Department of Health. The content, timeframe, and manner of submission of such updates shall be determined by the State Department of Health in consultation with the local health authority.

* * *

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for the regulatory amendments to Part 2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is section 225 of the Public Health Law (PHL), which authorizes the Public Health and Health Planning Council (PHHPC), subject to the approval of the Commissioner of Health (Commissioner), to establish and amend the State Sanitary Code (SSC) provisions related to any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York. Additionally, section 2103 of the PHL requires all local health officers to report cases of communicable disease to the New York State Department of Health (the “Department”).

Legislative Objectives:

The legislative objective of section 225 of the PHL is, in part, to protect the public health by authorizing the PHHPC, with the approval of the Commissioner, to amend the SSC to address public health issues related to communicable disease.

Needs and Benefits:

These regulations update and clarify the Department’s authority as well as that of local health departments (LHDs) to take specific actions to monitor the spread of disease, including actions related to investigation and response for a disease outbreak.

Specifically, the proposed regulatory amendments would add language to clarify and make explicit that the Commissioner may issue guidance that impacts investigation and response activities. For example, guidance may be issued instructing LHDs to prioritize full

investigations of varicella cases to those known to involve congregate residential settings and conduct investigations of other varicella cases only to the extent that resources allow, or guidance may provide details about the extent of investigation for a case of chlamydia in a pregnant individual. Regarding the timing for when investigation must commence, the regulation would change “immediately” to “with all due speed” to account for the fact that there is a range of appropriate response times depending on the condition and situation. In addition, the regulation would add “as necessary” to the provision requiring the local health authority to examine various factors associated with places related to an investigation “with the training or assistance of the State Department of Health”, to acknowledge that local health authorities will not always need training or assistance. Finally, the regulation would add “in consultation with the local health authority” to the provision stating that the Department shall determine the content and other characteristics of investigation updates, to acknowledge that the local health authority can provide valuable input.

COSTS:

Costs to Regulated Parties:

Although there are costs associated with disease investigation and response for any outbreak, these amendments merely clarify the existing authorities and responsibilities of local governments. As such, these amendments do not impose any substantial additional costs beyond what LHDs would incur in the absence of these amendments.

Further, making explicit the Department’s authority to issue guidance that impacts investigation activities will result in a more appropriate allocation of resources, possibly resulting in a cost-savings for State and local governments by reducing unnecessary investigatory

activities and allowing resources to be focused on investigations likely to have the greatest public health impact.

Costs to Local and State Governments:

Although there are costs associated with disease investigation and response for any outbreak, these regulations merely clarify the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations.

Further, making explicit the Department's authority to issue guidance that impacts investigation activities will result in a more appropriate allocation of resources, possibly resulting in a cost-savings for State and local governments.

Paperwork:

These amendments do not require any additional paperwork.

Local Government Mandates:

Under existing regulation, LHDs already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties.

Duplication:

There is no duplication in existing State or federal law.

Alternatives:

The alternative would be to leave in place the current regulations on disease investigation. However, these regulatory provisions clarify the regulation and provide additional flexibility to LHDs, while ensuring appropriate responses are taken for communicable disease outbreaks.

Federal Standards:

States and local governments have primary authority for controlling disease within their respective jurisdictions. Accordingly, there are no federal statutes or regulations that apply to disease control within New York State.

Compliance Schedule:

The regulations will become effective upon publication of a Notice of Adoption in the New York State Register.

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REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Business and Local Government:

Under existing regulation, local health departments (LHDs) already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments merely clarify these existing authorities and duties.

Compliance Requirements:

Under existing regulation, LHDs already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments merely clarify these existing authorities and duties.

Professional Services:

It is not expected that any professional services will be needed to comply with this rule.

Compliance Costs:

Although there are costs associated with disease investigation and response for any outbreak, these regulations merely clarify the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what LHDs would incur in the absence of these regulations being amended.

Further, making explicit the New York State Department of Health's ("the Department") authority to issue guidance that impacts investigation activities will result in a more appropriate allocation of resources, possibly resulting in a cost-savings for State and local governments.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

As the proposed amendments clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with regulated entities to ensure they are aware of the new regulations and have the information necessary to comply.

Small Business and Local Government Participation:

These proposed amendments to the regulation were previously discussed with the New York State Association of Counties Health Officials (NYSACHO) on three occasions and participants included both NYSACHO and LHD representatives. Discussions involved a detailed review of each of the submitted comments to the prior amendments adopted effective December 20, 2023 and a proposed approach to prioritize the initial scope of the regulatory amendments to incorporate the requested flexibility to prioritize investigation and response efforts at the local level, which is reflective of current practice and supported by both the Department and NYSACHO. These proposed amendments to the regulation are being proposed for permanent adoption, so all parties will have an opportunity to provide comments during the notice and comment period.

RURAL AREA FLEXIBILITY ANALYSIS

Type and Estimated Numbers of Rural Areas:

While this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), “rural area” means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as “counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population, ‘rural areas’ means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein.”

The following 44 counties have a population of less than 200,000 based upon 2020

United States Census data:

Allegany County	Greene County	Schoharie County
Broome County	Hamilton County	Schuyler County
Cattaraugus County	Herkimer County	Seneca County
Cayuga County	Jefferson County	St. Lawrence County
Chautauqua County	Lewis County	Steuben County
Chemung County	Livingston County	Sullivan County
Chenango County	Madison County	Tioga County
Clinton County	Montgomery County	Tompkins County
Columbia County	Ontario County	Ulster County
Cortland County	Orleans County	Warren County
Delaware County	Oswego County	Washington County
Essex County	Otsego County	Wayne County
Franklin County	Putnam County	Wyoming County
Fulton County	Rensselaer County	Yates County
Genesee County	Schenectady County	

The following 10 counties have populations of 200,000 or greater, and towns with population densities of 150 persons or fewer per square mile, based upon the United States Census estimated county populations for 2020:

Albany County
Dutchess County
Erie County

Monroe County
Niagara County
Oneida County
Onondaga County

Orange County
Saratoga County
Suffolk County

Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:

As the proposed regulations clarify existing responsibilities and duties among regulated entities and individuals, no additional recordkeeping, compliance requirements, or professional services are expected.

Compliance Costs:

As the proposed regulations clarify existing responsibility and duties among regulated entities and individuals, no initial or annual capital costs of compliance are expected above and beyond the cost of compliance for the requirements currently in 10 NYCRR Part 2.

Minimizing Adverse Impact:

As the proposed amendments to the regulations clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with local health departments (LHDs) to ensure they are aware of the new regulations and have the information necessary to comply.

Rural Area Participation:

These proposed amendments to the regulations are being proposed for permanent adoption, so all parties will have an opportunity to provide comments during the notice and comment period.

JOB IMPACT STATEMENT

The Department of Health has determined that this regulatory change will not have a substantial adverse impact on jobs and employment, based upon its nature and purpose.

SUMMARY OF EXPRESS TERMS

The proposed regulation would create a new section 405.46 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, to create cybersecurity requirements for all hospital facilities.

Section 405.46 (a) identifies all general hospitals in New York State as subject to the regulations.

Section 405.46 (b) defines certain terms and language for purposes of the section.

Section 405.46 (c) establishes the requirements for hospitals to have a cybersecurity program and defines protocols, procedures, and core functions of such program.

Section 405.46 (d) defines the cybersecurity policies that general hospitals will need to create and the topics that should be considered after a risk assessment has been performed.

Section 405.46 (e) requires general hospitals to designate a Chief Information Security Officer.

Section 405.46 (f) sets forth the requirements for testing and vulnerability of a general hospital's cybersecurity program.

Section 405.46 (g) outlines the audit trails and records maintenance and retention requirements of a general hospital's cybersecurity program.

Section 405.46 (h) sets forth the requirements for cybersecurity risk assessments and the considerations for policies and procedures relative to those risk assessments.

Section 405.46 (i) sets forth the requirements for cybersecurity personnel general hospitals must utilize.

Section 405.46 (j) sets forth the policies for third-party service providers of cybersecurity programs.

Section 405.46 (k) sets forth the requirements for identity and access management.

Section 405.46 (l) sets forth the requirements for training and monitoring of the cybersecurity program.

Section 405.46 (m) defines the requirements for an incident response plan in the event of a cybersecurity incident.

Section 405.46 (n) defines the reporting requirements for a general hospital during a cybersecurity incident.

Section 405.46 (o) refers to confidentiality and the applicability of State and federal statutes.

Section 405.46 (p) provides general hospitals one (1) year from the date of adoption to comply with the new regulatory requirements, except that general hospitals must immediately begin reporting to the Department as required by subdivision (n) of this section.

Section 405.46 (q) states that if any provisions of the section are found to be invalid, it shall not affect or impair the validity of other provisions of the section.

Pursuant to the authority vested in the Commissioner of Health by section 2803 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by adding a new section 405.46, to be effective upon publication of the Notice of Adoption in the State Register, to read as follows:

405.46 Hospital Cybersecurity Requirements

(a) Applicability. This section shall apply to all general hospitals licensed pursuant to article 28 of the Public Health Law, referred to throughout this section as “hospitals.”

(b) Definitions. For the purposes of this section the following terms shall have the following meaning:

(1) “Authorized user” means any employee, contractor, agent or other person that participates in or operates on behalf of the operations of a hospital and is authorized to access and use any information systems and data of such hospital.

(2) “Control” means any mechanism, safeguard, policy or security measure that is put into place pursuant to implementation specification, to satisfy the requirement for a security measure.

(3) “Compensating Control” means any alternative measure that is put into place to satisfy the requirement for a security measure, where the implementation specification for that requirement is deemed not reasonable or appropriate to implement. The hospital must document why it would not be reasonable and appropriate to implement the implementation specification; and implement an equivalent alternative measure if reasonable and appropriate.

(4) “Cybersecurity event” means any act or attempt, successful or unsuccessful, to gain unauthorized access to, disrupt or misuse the hospital’s information system or information stored on such information system, including but not limited to health records.

(5) “Cybersecurity incident” means a cybersecurity event that:

(i) has a material adverse impact on the normal operations of the hospital, or;

(ii) has a reasonable likelihood of materially harming any part of the normal operation(s) of the hospital; or

(iii) results in the deployment of ransomware within a material part of the hospital’s information systems.

(6) “Information system” means a discrete set of electronic information resources organized for the collection, processing, storage, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system such as industrial/process controls systems, telephone switching and private branch exchange systems, and environmental control systems. One such example is an electronic health records system.

(7) “Multi-factor authentication” means authentication that requires more than one distinct authentication factor for successful authentication. The three authentication factors are:

(i) knowledge factors (i.e. something you know), such as a PIN or a password;

(ii) possession factors (i.e. something you have), such as a cryptographic identification device or a token;

(iii) inherence factors (i.e. something you are), such as a biometric characteristic.

(8) “Nonpublic information” means all electronic information that is not publicly available information and is:

- (i) a hospital's business-related information, the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of such hospital;
- (ii) Personally identifiable information (PII) including any information concerning a natural person which because of name, number, personal mark, or other identifier can be used to identify such natural person. This includes any information in combination with any one or more of the following data elements, when either the data element or the combination of personal information plus the data element is not encrypted, or is encrypted with an encryption key that has also been accessed or acquired, in combination with any one or more of the following data elements:
 - (a) social security number;
 - (b) drivers' license number or non-driver identification card number;
 - (c) account number, credit or debit card number in combination with any required security code or access code;
 - (d) password or other information that would permit access to an individual's financial account;
 - (e) account number, credit or debit card number, if circumstances exist wherein such number could be used to access an individual's financial account without additional identifying information, security code, access code or password; or
 - (f) biometric information, meaning data generated by electronic measures of an individual's unique physical characteristics, such as a fingerprint, voice print, retina or iris image, or other unique physical representation or digital representation of biometric data which are used to authenticate or ascertain the individual's identity; or a username or email address in combination

with a password or security question and answer that would permit access to an online account;
or

(ii) Protected Health Information (PHI), as defined under 45 CFR 160.103, including but not limited to, any information or data, in any form or medium created by, held by, transmitted by, or derived from a health care provider or an individual and that relates to:

(a) the past, present or future physical, mental or behavioral health, or condition of any individual or a member of the individual's family;

(b) the provision of health care to any individual; or

(c) payment for the provision of health care to any individual.

(9) “Penetration testing” is a test methodology in which assessors attempt to circumvent or defeat the security features of an information system from outside or inside the hospital’s information systems.

(10) “Privileged account” means any authorized user account or service account that can be used to perform security-relevant functions that ordinary users are not authorized to perform, including but not limited to the ability to add, change or remove other accounts, or make configuration changes to information systems.

(11) “Publicly available information” means any information that a hospital has a reasonable basis to believe is lawfully made available to the general public from widely distributed media; or disclosures to the general public that are required to be made by Federal, State or local law.

For the purposes of this paragraph, a hospital has a reasonable basis to believe that information is lawfully made available to the general public if the hospital has taken steps to determine that:

(i) the information is of the type that is available to the general public;

(ii) no individual who could have lawfully objected to the information being disclosed to the general public, has made such a request; and

(iii) disclosure to the general public would not violate other Federal, State, or local government laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA).

(12) “Risk assessment” means the risk assessment that each hospital must conduct under subdivision (h) of this section.

(c) Cybersecurity Program Requirements.

(1) Each hospital shall establish within its policies and procedures a cybersecurity program based on the hospital’s risk assessment.

(2) The cybersecurity program shall be designed to perform the following core functions:

(i) identify and assess internal and external cybersecurity risks that may threaten the security or integrity of nonpublic information stored on the hospital’s information systems and the continuity of the hospital’s business and operations;

(ii) use defensive infrastructure and the implementation of policies and procedures to protect the hospital’s information systems, the continuity of the hospital’s business and operations, and the nonpublic information stored on those information systems, from unauthorized access, use or other malicious acts;

(iii) detect cybersecurity events;

(iv) respond to identified or detected cybersecurity events to mitigate any negative effects;

(v) recover from cybersecurity events and incidents and restore normal operations and services; and

(vi) fulfill applicable statutory and regulatory reporting obligations.

(3) Each hospital's cybersecurity program shall include policies and protocols to limit user access privileges to information systems that provide access to nonpublic information. Each hospital shall periodically review such access privileges, and such access privileges shall be based on the hospital's risk assessment, and other State and Federal laws, including but not limited to the administrative, physical and technical safeguards under HIPAA.

(4) Each hospital's cybersecurity program shall include written procedures, guidelines and standards designed to ensure the use of secure development practices for in-house developed applications utilized by the hospital, and procedures for evaluating, assessing and testing the security of externally developed applications utilized by the hospital. All such procedures, guidelines and standards shall be annually reviewed, assessed, updated and attested as such by the chief information security officer (CISO) (or a qualified designee) of the hospital.

(5) Each hospital's cybersecurity program shall include policies and procedures for the secure disposal, on a periodic basis, of any nonpublic information identified that is no longer necessary for business operations or for other legitimate business purposes of the hospital, except where such information is otherwise required to be retained by law or regulation, or where targeted disposal is not reasonably feasible due to the manner in which the information is maintained.

(6) Each hospital's cybersecurity program shall implement security measures and controls, including encryption, to protect nonpublic information held or transmitted by the hospital, both in transit over external networks and at rest, which takes into account necessary controls identified in the hospital's risk assessment.

(i) To the extent a hospital determines that encryption of nonpublic information in transit over external networks is infeasible, the hospital shall instead secure such nonpublic information using effective compensating controls reviewed and approved by the hospital's CISO.

(ii) To the extent a hospital determines that encryption of nonpublic information at rest is infeasible, the hospital shall instead secure such nonpublic information using effective alternative compensating controls reviewed and approved by the hospital's CISO.

(iii) To the extent that a hospital is utilizing compensating controls under this paragraph, the feasibility of encryption and effectiveness of the compensating controls shall be reviewed and documented by the CISO as needed to continue securing nonpublic information. Such reviews and associated documentation shall be completed at minimum on an annual basis.

(7) Each hospital's cybersecurity program shall implement security controls to mitigate risks arising from electronic mail-based threats, including but not limited to spoofing, phishing, and fraud. Such controls shall be reviewed and updated on a regular basis to ensure their effectiveness against evolving threats.

(d) Cybersecurity policy.

(1) Each hospital shall maintain and implement policies and procedures for the protection of its information systems and nonpublic information stored on those information systems, and the continuity of the hospital's business and operations, in accordance with the hospital's risk assessment and applicable State and Federal laws and regulations. The hospital shall be responsible for developing and enforcing the hospital's cybersecurity policy, and overseeing and implementing the hospital's cybersecurity program, established pursuant to subdivision (c) of this section.

(2) The hospital's cybersecurity policy, upon recommendation by the CISO shall be approved by the hospital's governing body, established pursuant to section 405.2 of this Part. If a committee is established for the specific purpose of supervising the hospital's cybersecurity measures, the

committee shall present the cybersecurity policy to the governing body for full approval and implementation.

(3) The cybersecurity policies shall be based on the hospital's risk assessment and address, at a minimum, the following topics:

- (i) information security;
 - (ii) data governance and classification;
 - (iii) asset inventory and device management;
 - (iv) access controls and identity management;
 - (v) business continuity and disaster recovery planning and resources;
 - (vi) systems operations and availability concerns;
 - (vii) systems and network security;
 - (viii) systems and network monitoring;
 - (ix) systems and application development and quality assurance;
 - (x) physical security and environmental controls;
 - (xi) patient data privacy;
 - (xii) vendor and third-party service provider management;
 - (xiii) risk assessment as defined in subdivision (h) of this section;
 - (xiv) training and monitoring as defined in subdivision (l) of this section; and
 - (xv) overall incident response as defined in subdivision (m) of this section;
- (e) Chief Information Security Officer.

(1) Each hospital shall designate an individual from senior- or executive-level staff, qualified in training, experience, and expertise, to serve as the hospital's Chief Information Security Officer, or "CISO."

(2) Notwithstanding the provisions set forth in subdivision (i) of this section, the hospital's CISO may be an employee of the facility, or an employee of a third-party or contract vendor. If the CISO is an employee of a third-party or contract vendor, the governing body, as defined under section 405.2 of this Part, shall approve the contract on an annual basis.

(3) The CISO of each hospital shall report in writing, at least annually to the hospital's governing body, on the hospital's cybersecurity program and material cybersecurity risks. Such report shall, at minimum include:

(i) the confidentiality of nonpublic information and the integrity and security of the hospital's information systems;

(ii) the hospital's cybersecurity policies and procedures, including their implementation status and any recommendations for revisions;

(iii) material cybersecurity risks to the hospital;

(iv) overall effectiveness of the hospital's cybersecurity program; and

(v) any cybersecurity incidents as defined herein involving the hospital during the time period addressed by the report, as well as steps taken to mitigate future events.

(f) Testing and vulnerability assessments.

(1) The cybersecurity program for each hospital shall include monitoring and testing, developed in accordance with the hospital's risk assessment, designed to assess the effectiveness of the hospital's cybersecurity program and assess changes in information systems that may create or indicate vulnerabilities.

(2) The monitoring and testing shall include at a minimum:

(i) penetration testing of the hospital's information systems by a qualified internal or external party at least annually based upon the hospital's risk assessment;

(ii) automated scans or manual or automated reviews of information systems reasonably designed to identify publicly known cybersecurity vulnerabilities in the hospital's information systems based on the risk assessment; and

(iii) timely remediation of vulnerabilities based on the risk they pose to the hospital.

(g) Audit Trails and Records Maintenance.

(1) Each hospital shall securely maintain systems that are designed to support normal operations and obligations of the hospital. Records pertaining to systems design, security, and maintenance supporting such normal operations shall be maintained for a minimum of six years.

(2) Each hospital shall also securely maintain systems to include audit trails designed to detect and respond to cybersecurity events that have a reasonable likelihood of materially harming any material part of the normal operations of the hospital, and cybersecurity incidents as defined herein. Records pertaining to such audit trail systems shall be maintained for a minimum of six years.

(3) Designs for the security systems and audit trails required pursuant to paragraphs (1) and (2) of this subdivision shall be based on the hospital's risk assessment.

(h) Risk assessment.

(1) Each hospital shall conduct an accurate and thorough annual risk assessment of the hospital's potential risks and vulnerabilities to the confidentiality, integrity, and availability of nonpublic information, such as electronic protected health information, held by the hospital, and the continuity of the hospital's business and operations, as well as information systems sufficient to inform the design of the cybersecurity program as required by this section. Such risk assessment shall be updated as reasonably necessary, and no less than annually, and address changes to the hospital's information systems, nonpublic information or business operations supported by those

information systems. The risk assessment shall allow for revision of controls to respond to technological developments and evolving threats and shall consider the particular risks of the hospital's business operations, nonpublic information collected or stored, information systems utilized and the availability and effectiveness of controls to protect nonpublic information and information systems. Risk assessments performed for other regulatory purposes, such as HIPAA, shall be acceptable under this provision provided they comport with the requirements herein. Other risk assessments performed for other regulatory purposes, such as HIPAA, may be extended to comply this section and incorporate other risk assessments performed by qualified internal or external parties.

(2) The risk assessment shall be carried out in accordance with written policies and procedures and shall be documented. Such policies and procedures shall, at a minimum include:

(i) criteria for the evaluation and categorization of identified cybersecurity risks, vulnerabilities, and threats facing the hospital;

(ii) criteria for the assessment of the confidentiality, integrity, security and availability of the hospital's information systems and nonpublic information, including the identification and adequacy of existing controls in the context of identified risks, the determination of the likelihood of threat occurrence and the determination of the potential impact on threat occurrence, and the determination of the level of risk; and

(iii) requirements describing how identified risks and threats will be mitigated or accepted based on the risk assessment and how the cybersecurity policies and programs will address the risks.

(i) Cybersecurity personnel.

(1) Each hospital shall:

(i) utilize qualified cybersecurity personnel of the hospital, an affiliate or a third-party service provider sufficient to manage the hospital's cybersecurity risks and to perform or oversee the performance of the core cybersecurity functions specified in subdivision (c) of this section and in accordance with the hospital's risk assessment;

(2) Each hospital may utilize an affiliate or qualified third-party service provider to assist in complying with the requirements set forth in this section.

(j) Security policies for third-party service providers.

(1) Each hospital shall implement written policies and procedures designed to ensure the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers. Such policies and procedures shall be based upon the hospital's risk assessment and shall, at a minimum, address the following:

(i) the identification and baseline assessment (if applicable) of third-party service providers; and
(ii) minimum cybersecurity practices required to be met by such third-party service providers in order for them to do business with the hospital.

(2) Such policies and procedures shall include relevant guidelines for due diligence and contractual protections relating to third-party service providers, including, at a minimum, guidelines addressing:

(i) ensuring third-party service provider's policies and procedures for access controls are consistent with industry standards;

(ii) the third-party service provider's policies and procedures for use of encryption or another method to protect nonpublic information in transit and at rest;

(iii) notice to be provided to the hospital in the event of a cybersecurity incident directly impacting the hospital's information systems or the hospital's nonpublic information being held by the third-party service provider; and

(iv) representations and warranties addressing the third-party service provider's cybersecurity policies and procedures that relate to the security of the hospital's information systems or nonpublic information.

(k) Identity and Access Management.

(1) Each hospital shall use multi-factor authentication, risk-based authentication, or other compensating control to protect against unauthorized access to nonpublic information or information systems.

(2) Multi-factor authentication shall be utilized for any individual accessing the hospital's internal networks from an external network, unless the hospital's CISO has approved in writing the use of compensating controls.

(3) Each hospital shall limit user access privileges to information systems that provide access to nonpublic information to only those necessary to perform the user's job;

(4) Each hospital shall separate non-privileged and privileged accounts;

(5) Each hospital shall limit the number of privileged accounts and limit the access functions of privileged accounts to only those necessary to perform the user's job;

(6) Each hospital shall limit the use of privileged accounts to only when performing functions requiring the use of such access;

(7) Each hospital shall periodically, but at a minimum annually, review all user access privileges and remove or disable accounts and access that are no longer necessary;

(8) Each hospital shall disable or securely configure all protocols that permit remote control of devices; and

(9) Each hospital shall promptly terminate access following departures.

(l) Training and monitoring.

As part of its cybersecurity program, each hospital shall, at a minimum:

(1) Implement risk-based policies, procedures and controls designed to monitor the activity of authorized users and detect unauthorized access or use of, or tampering with, nonpublic information by such authorized users.

(2) Provide regular cybersecurity awareness training for all personnel that is updated to reflect risks identified by the hospital in its risk assessment, which may include annual phishing exercises and training/remediation for employees.

(m) Incident response plan.

(1) As part of its cybersecurity program, each hospital shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity incident materially affecting the confidentiality, integrity or availability of the hospital's information systems or the continuing functionality of any aspect of the hospital's business or operations.

(2) Such incident response plan shall, at a minimum, address the following areas:

(i) the goals of the incident response plan;

(ii) the definition of clear roles and responsibilities, a list of actual personnel and both business hour and off-business hour contact information with levels of decision-making authority;

(iii) external and internal communications and information sharing about any incidents;

(iv) identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;

(v) the internal processes for responding to a cybersecurity event including, at a minimum, mitigation, downtime procedures and contingency plan, and process for determining if a cybersecurity event becomes a cybersecurity incident, and processes for determining if a cybersecurity incident has a material adverse impact on the hospital;

(vi) documentation and reporting regarding cybersecurity events and related incident response activities; and

(vii) the evaluation and revision as necessary of the incident response plan following a cybersecurity event.

(n) Department Reporting.

(1) The hospital or their designee shall notify the department as promptly as possible, but no later than 72 hours after determining a cybersecurity incident, as defined herein, has occurred, in a manner prescribed by the department. Notification to the department under this section does not replace any other notifications required under State or Federal laws or regulations.

(2) Each hospital shall maintain and submit for examination, in such time and manner and containing such information, as the department determines to be necessary, including but not limited to any and all documentation, such as records, schedules, reports, and data required and supporting the required documentation by this section. All such documentation must be maintained for a minimum of six years.

(3) To the extent a hospital has identified areas, systems or processes that require material improvement, updating or redesign, the hospital shall document the identification and the remedial efforts planned, and underway, to address such areas, systems or processes. Such documentation must be available for inspection by the department, in such time and manner as prescribed by the department, and must be maintained for a minimum of six years.

(o) Confidentiality.

Information provided by a hospital pursuant to this Part shall be subject to the applicable provisions of the Public Health Law, Mental Hygiene Law, Education Law, and the Public Officers Law or any other applicable State or Federal law or regulations in relation to disclosure.

(p) Compliance period.

(1) Covered entities shall have one year from the effective date of this section to comply with the requirements set forth herein, provided, however, subdivision (n) of this section shall be effective immediately upon adoption.

(q) Severability.

If any provision of this section or the application thereof to any person or circumstance is adjudged invalid by a court of competent jurisdiction, such judgment shall not affect or impair the validity of the other provisions of this section or the application thereof to other persons or circumstances.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) § 2803(2)(a) authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner of Health (Commissioner), to implement PHL Article 28 and establish minimum standards for health care facilities, including general hospitals.

Legislative Objectives:

The legislative objectives of PHL Article 28 include the protection of the health of the residents of the State by promoting the efficient provision and proper utilization of high-quality health services at a reasonable cost.

These regulations fulfill this legislative objective by ensuring that general hospitals within New York State implement minimum cybersecurity controls to safeguard protected health information (PHI) and personally identifying information (PII) from being publicly disclosed or used for identity theft.

Needs and Benefits:

The healthcare industry is one of the most targeted communities for cybersecurity scams and breaches due to the significant amount of sensitive and financially lucrative information healthcare facilities collect. Currently in New York State there are no cybersecurity requirements for the safeguarding and security of patients' protected health information (PHI) and personally identifying information (PII). As a result, New Yorkers seeking medical care

have no guaranteed minimum levels of protection of their information. As a result of this, there have been several high-profile cybersecurity breaches at facilities across the state which have resulted in not only a loss of patient financial and health data, but in some cases has also delayed care.

Additionally, cybersecurity events at hospitals can have significant, far-reaching, and long-term impacts to the provision of patient care and operation of the facility. Governor Hochul has been focusing on cybersecurity and ensuring that New Yorkers data stays safe no matter where they go. The promulgation and implementation of cybersecurity focused regulations supports this initiative. These regulations will ensure all hospitals develop, implement, and maintain minimum cybersecurity standards, including cybersecurity staffing, network monitoring and testing, policy and program development, employee training and remediation, incident response, appropriate reporting protocols and records retention.

There will be multiple benefits to the adoption of these regulations. Given the significant differences in preparedness statewide against cybersecurity attacks, these regulations will ensure hospitals are required to maintain a minimum level of readiness to prepare for, respond to, and quickly recover from cybersecurity incidents.

Costs:

Costs to Regulated Parties:

The costs associated with the implementation by regulated facilities will vary significantly due to the varying levels of cybersecurity programs and policies hospitals currently have in place. Some facilities may have mature monitoring, training and response programs, whereas others may not. Therefore, the costs could vary from tens of thousands to tens of millions. Hospitals will be allowed to sub-contract for cybersecurity services and this may reduce

the overall cost of program implementation. It is estimated that effective cybersecurity programs can cost between \$250,000 and \$10 Million to develop and implement initially and anywhere from \$50,000 - \$2 Million or more to maintain on a yearly basis depending on the facility size. For small hospitals (of which there are 15 and are defined as less than 10 acute care or ICU beds), ongoing annual costs are estimated to be \$50,000-\$200,000. For medium sized hospitals (of which there are 62 and are defined as those with between 10 and 100 beds), ongoing costs are estimated to be \$200,000-\$500,000. For large hospitals (of which there are 114 and are defined as those with more than 100 beds), ongoing annual costs are estimated to be \$2 million.

Costs to Local and State Governments:

There are currently fifteen facilities which would be subject to these proposed regulations which are operated by local municipalities. As such, they would be subject to the same regulations as those operated by private entities. The estimated costs they would incur would depend on their size, as noted above.

Local Government Mandates:

These regulations do impose a program, service, duty or other responsibility upon 4 separate city, county and State governments to the extent they do not already comply with the proposed regulations.

Paperwork:

These regulations impose additional paperwork in the form of procedures, policies, guidelines, and reporting documents. These requirements are necessary to ensure the efficacy of a cybersecurity program and also provide accountability and transparency for hospitals.

Duplication:

There is no duplication of this initiative in existing State law. The Health Insurance Portability and Accountability Act (HIPAA) Security Rule does provide broad requirements for safeguarding PHI, but the regulations contained herein are intended to supplement HIPAA.

Alternatives:

The alternative to the proposed regulation would be not enacting the cybersecurity requirements. This option is not appropriate due to the demonstrated need to protect PHI and PII at hospitals within the State. The Department in 2023 has responded to more than 1 cybersecurity incident per month, several of which have forced hospitals to go on diversion, stopped their billing procedures, and required facilities to operate on downtime procedures which can severely hamper the care delivery process. Over 225,000 patients had data possibly compromised in one breach alone.

In order to respond to comments received by facilities, the proposed regulations were modified to lengthen and simplify the compliance period in order to maximize the ability for facilities to come into compliance. Furthermore, the Department removed the requirement for a Chief Information Security Officer to be employed directly by the facility, and instead allow them to be a virtual or 3rd party vendor upon approval by the facilities' governing body.

Federal Standards:

Federal regulations governing protection of PHI and PII are contained within HIPAA, however they are overly vague and provide limited guidance on cybersecurity and the protection of PHI and PII.

Compliance Schedule:

General hospitals will have one year from the effective date of the regulation to comply with the requirements set forth herein. However, subdivision (n) of the regulation, requiring general hospitals to notify the department as promptly as possible, but no later than 72 hours after determining a cybersecurity incident, as defined herein, has occurred, will be effective upon adoption in the State Register. The schedule as proposed was modified as a direct result of outreach to facilities by the Department who provided feedback on the difficulty in developing cybersecurity programs.

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The proposed regulations will affect all general hospitals licensed pursuant to Article 28 of the Public Health Law, regardless of size or location. There are currently 226 hospitals in New York State, including Veteran's Affairs facilities (which would not be affected by these proposed regulations). These regulations will not affect local governments unless they operate a general hospital. In NYS, there are 15 hospitals operated by municipalities; Lewis County Hospital in Lewis County, NY, Wyoming County Hospital in Wyoming County, 12 facilities operated by New York City Health and Hospitals Corporation, and Helen Hayes hospital operated by the State of New York.

Currently in New York State there are no cybersecurity requirements for the safeguarding and security of patients' protected health information (PHI) and personally identifying information (PII). As a result, New Yorkers seeking medical care have no guaranteed minimum levels of protection of their information. As a result of this, there have been several high-profile cybersecurity breaches at facilities across the state which have resulted in not only a loss of patient financial and health data, but in some cases has also delayed care. Additionally, cybersecurity events at hospitals can have significant, far-reaching, and long-term impacts to the provision of patient care and operation of the facility. These regulations will ensure all hospitals develop, implement, and maintain minimum cybersecurity standards, including cybersecurity staffing, network monitoring and testing, policy and program development, employee training and remediation, incident response and appropriate reporting protocols and records retention.

Compliance Requirements:

The proposed regulations require that hospitals develop, implement and maintain minimum cybersecurity standards and programs, including information technology (IT) staffing, network monitoring and testing, policy and program development, employee training and remediation, incident response, appropriate reporting protocols and records retention.

Professional Services:

Depending on the current state of an existing cybersecurity program, a facility or system may need to contract with a third-party service provider for anything from staffing, network monitoring, incident response, or staff training. Facilities will be required to hire or appoint a Chief Information Security Officer (CISO). The draft regulations currently allow for the CISO to be a direct employee of the facility, or an employee of a virtual or third-party contractor upon consent and approval of the governing body. Facilities may also need to hire or contract additional information technology staff to ensure compliance with the new regulations. Additionally, the facilities may need to purchase information security programs or contract with third-party vendors to monitor for malicious network traffic, perform compliance testing with authorized users and ensure protected health information and personally identifying information is kept secure.

Compliance Costs:

Given the variability in cybersecurity preparedness and current programs at facilities, the initial startup and ongoing costs could vary significantly. After initial conversations with facilities to gain a basic understanding of costs, it is estimated that effective cybersecurity

programs can cost millions to develop and implement initially, and anywhere from \$50,000-\$2 million or more to maintain on a yearly basis depending on the facility size. For small hospitals (of which there are 15 and are defined as less than 10 acute care or ICU beds), ongoing annual costs are estimated to be \$50,000-\$200,000. For medium sized hospitals (of which there are 62 and are defined as those with between 10 and 100 beds), ongoing costs are estimated to be \$200,000-\$500,000. For large hospitals (of which there are 114 and are defined as those with more than 100 beds), ongoing annual costs are estimated to be \$2 million.

Economic and Technological Feasibility:

It is both economically and technologically feasible for hospitals to become compliant with the proposed regulations. There currently exists a significant amount of technology and software which can be licensed or purchased to provide network monitoring, notification, staff training and exercises and multifactor or risk-based authentication, among others. Economically, it will be easier for hospitals which are part of large healthcare systems or located in more urban areas to comply with these regulations than it may be for smaller or more rural facilities. This is due to the fact that the larger facilities and systems may already have aspects of the regulations already functioning as part of a mature cybersecurity program, or may have access to more capital and resources than smaller, more rural or standalone facilities. While several facilities voiced concerns related to the cost of implementation, the consequences of what can occur as a result of a cyber-attack far outweigh those costs. Days or weeks of downtime with an inability to bill for services can cost tens of millions of dollars (at a minimum), as well as the unknown cost of lost productivity, cancellation of elective surgeries, purchase of new computers, etc, can well exceed the yearly maintenance program costs.

Minimizing Adverse Impact:

The Department of Health conducted several rounds of outreach to affected healthcare facilities and healthcare associations as part of the regulatory drafting process, to understand what makes a successful cybersecurity program, what things should be avoided or be flexible, and how the Department can work with them to enhance preparedness in New York State. As a result of those discussions, the Department took significant steps to ensure that no specific references to technology, programs or software were included into the regulations. In this way, it allows for facilities to become compliant with the regulations however they may be able to, without the regulation becoming too prescriptive, or requiring use of overly expensive or specific software. These regulations establish truly baseline, general requirements that allow maximum flexibility to healthcare facilities to comply based on their operations. While other approaches to cybersecurity programs were considered, as required under SAPA § 202-b(1), there are unfortunately no alternatives to cybersecurity, as the health and welfare of patients both current and former at a facility can be adversely affected by a network breach. Facilities will have one year from implementation to come into compliance with the regulations except for incident reporting. The compliance period as proposed will not only maximize the ability for facilities to come into compliance, but was modified as a result of feedback received from those facilities. While these regulations will result in some cost to facilities, the Department will be taking action to mitigate these impacts. In January of this year, the Department released Statewide IV and Statewide V funding totaling \$650 million to assist with implementation of, and compliance with, the regulatory requirements. This funding was appropriated in the SFY 24 budget with the intention of supporting facilities' technological needs, including for cybersecurity purposes.

Small Business and Local Government Participation:

During the drafting process, the Department conducted several rounds of outreach to over 25 different hospitals and hospital/healthcare associations to understand the current state of the industry, cybersecurity program best practices and areas to avoid.

Parties the Department reached out to:
University of Rochester MC
Kaleida Health
Northwell Health
NY Presbyterian
Elizabethtown Hospital
Arnot Ogden MC
Geneva General Hospital
Soldiers and Sailors Memorial Hospital
Rochester General Hospital
Unity Hospital
Wyoming County Hospital
Richmond University Medical Center
Healthcare Association of NYS
Iroquois Healthcare Association
Healthcare Association of Central and Western NY
Suburban Hospital Alliance of NYS
Greater NY Healthcare Association

As there are facilities run by city, county and state municipalities, a cross section of them was invited to participate in the roundtable discussion related to cybersecurity programs and proposed regulations. The Department has some direct communication methods through the Health Commerce system which will be utilized to reach out to C Suite executives at each facility after the regulations are publicly posted and available for comment.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

Rural areas as defined by Executive Law § 418(7) are counties with a population less than 200,000 and towns with a population density less than 150 people per square mile. For the purposes of this regulation, there are 44 counties with a population of less than 200,000, which have a total of 76 regulated facilities. The proposed rule will apply statewide to all general hospitals regulated under Article 28 of the Public Health Law.

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

1. Recordkeeping- Article 28 facilities will be required to develop cybersecurity policies, protocols and procedures within one year of the adoption of the proposed regulations. Facilities will be required to maintain records of program compliance by employees, security breaches by outside entities (both successful and unsuccessful), and other program documentation for at least 6 years.
2. Reporting: Article 28 facilities will be required to report any cybersecurity incidents, as defined in the proposed regulation, as promptly as possible, but no later than 72 hours after determining a cybersecurity incident has occurred. Facilities will also be required to provide a report to the Department upon request of all cybersecurity incidents within the previous reporting period.
3. Professional services- Facilities will be required to hire or appoint a Chief Information Security Officer (CISO). The draft regulations currently allow for the CISO to be a direct employee of the facility, or an employee of a virtual or third-party contractor upon consent and approval of the governing body. Facilities may also need to hire or contract

additional information technology staff to ensure compliance with the new regulations. Additionally, the facilities may need to purchase information security programs or contract with third-party vendors to monitor for malicious network traffic, perform compliance testing with authorized users and ensure protected health information, personally identifying information, and nonpublic information is kept secure.

Costs:

The costs for this program will vary depending on the level of preparedness of each facility. For less mature programs which require significant development, the initial funding required could range from \$250,000 to \$10 million. For small hospitals (of which there are 15 and are defined as less than 10 acute care or ICU beds), ongoing annual costs are estimated to be \$50,000-\$200,000. For medium sized hospitals (of which there are 62 and are defined as those with between 10 and 100 beds), ongoing costs are estimated to be \$200,000-\$500,000. For large hospitals (of which there are 114 and are defined as those with more than 100 beds), ongoing annual costs are estimated to be \$2 million. Facilities may be able to purchase equipment or services from State Contract lists where appropriate and applicable. Facilities will also be able to contract with appropriate third-party vendors or contractors to help ensure compliance with the proposed regulations.

Minimizing Adverse Impact:

The Department has included flexibility within the regulations for facilities to ensure they are compliant with the requirements, including allowing for third-party or vendor contractors to complete compliance reporting and measures on behalf of them. Additionally, facilities will have

one year from the adoption of the proposed regulations to implement the requirements and ensure compliance. While these regulations will result in some cost to facilities, the Department will be taking action to mitigate these impacts. In January of this year, the Department released Statewide IV and Statewide V funding totaling \$650 million to assist with implementation of, and compliance with, the regulatory requirements. This funding was appropriated in the SFY 24 budget with the intention of supporting facilities' technological needs, including for cybersecurity purposes.

Rural Area Participation:

In consideration of SAPA § 202-bb(7), the Department conducted multiple rounds of outreach with facilities of a diversity of sizes, including those located in rural areas such as Ellenville Regional Hospital and Arnot Ogden Medical Center. This outreach consisted of one-on-one conference calls with specific facilities, which occurred June 12-22, 2023, as well as a roundtable in August 2023 where over 25 facilities, healthcare associations and Department of Health staff were invited to discuss the current state of cybersecurity programs, best practices and required elements of a good cybersecurity program. While many facilities agreed about the need for mature cybersecurity program amid increasing cybersecurity threats, many voiced concerns about the costs of these programs. The Department listened to all of the feedback provided and modified some of the language in the proposed regulations. For example, the Department simplified and lengthened the compliance period to allow facilities the maximum amount of time to be in compliance.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purpose of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.